MEDICARE CLAIMS PROCESSING SYSTEM (MCPS)

BEST PRACTICES PRESENTATION

FOR MTS

SEPTEMBER 22, 1994

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I. MEDICAL REVIEW/FOCUSED MEDICAL REVIEW

A. MCPS MEDICAL REVIEW PROCESS

The MCPS Medical Review adjudication is a very efficient process that is done with a minimum of manual intervention by the Medical Review analyst.

1. Automated Functions

- Claims meeting the FMR criteria are suspended to and can be accessed via an on-line Medical Review index.
- Suspended data appears on the on-line index in an aged-sequence order.
- If required by the criteria, a request for medical records is automatically generated by MCPS. The Medical Review Index is updated automatically indicating that records have been requested.
- The medical analysts can generate on-line requests for additional medical records via the Nurse's Page.
- If requested records are not received in the time allotted by Medicare regulations, the claim is deleted from the system and a letter is automatically generated and sent to the provider.
- The system automatically generates a full or partial denial letter.

2. *Nurse's Page*

The last page of the claim record is the Nurse's Page, which can only be accessed by authorized MR personnel. MCPS identifies authorization through Operator Identification This page is carried through the system to claim history. In addition to assuring that a medical necessity determination can only be completed by personnel with appropriate clinical training, it provides a systematic internal control over medical review determination.

The Nurse's Page is used for all of the following functions:

- Requesting additional records for more detailed information
- Approvals
- Full denials
- Partial denials
- Entering desired letter codes for customized letter generation, including fill-in letter information
- Entering remarks

a. Request Records

From the Nurse's Page, the analyst types the data required according to the records that are being requested.

b. Approval

The medical analyst adjudicates a claim relative to its compliance with Medicare regulations after all necessary information has been received. The medical analyst reviews the claim on-line and if all of the charges on a claim are determined to be covered, the claim is released for payment.

c. Full Denial

If the charges on a claim are determined to be noncovered, the claim is considered a denied claim. On the Nurse's Page, a denial decision is entered, as well as, a letter code for the type of letter to be automatically generated and sent to the provider and the beneficiary. MCPS automatically moves all charges to the noncovered column with totals.

d. Partial Denial

If the analyst determines that only some of the charges on the claim are covered, the covered charges are released for payment. On the Nurse's Page, the denial decision is entered for each non-covered charge and a letter code is entered for the type of letter to be automatically generated and sent out to the provider and the beneficiary.

3. PC Capabilities

For letter generation and data collection and manipulation purposes, MCPS downloads automatically to the PC based component of the MCPS system.

- Data from reviewed claims is downloaded to a personal computer system and is used for statistical analysis and for mandated and ad hoc reporting purposes.
- The post-payment review function is initiated through the PC component of the MCPS system.
- Maintains statistical logs of all reviewed claims
- Data from adjudicated claims referred to MR can be reported monthly and quarterly in a standardized format

B. FOCUSED MEDICAL REVIEW

This referral system provides Users with the capability to update pre-payment medical review referral criteria on-line, real time without intervention by Systems personnel.

1. FMR Process

- The User can add, delete, inactivate, reactivate, and test claim referral criteria and also submit them into production within the same day.

- Referral criteria is set up using the Claim Referral entry screen, and modified using the Claim Referral Update screen. The following data elements can be used for selection criteria: Provider Number, Diagnosis Code, Revenue Code, HCPCS Code, Procedure Code, Occurrence Code/Date, Value Code/Amount, Condition Code, Attending Physician, Received Date, From Date, Through Date, Revenue Units, Length of Stay, HIC Number, Total Charges and Patient Status.

- Users also have the capability to set up automatic records requests and/or automatic denials for any claims that are referred based on the selected criteria.

- The Claim Referral Summary screen allows the User to view referral criteria, initiate specific actions (delete, inactivate, reactivate) on referral criteria, activate referral criteria testing, and move test criteria into production.

FMR Process cont.-

- The testing function allows Users to use production data to test the results of different referral criteria. This testing can be done immediately on-line, and a paper copy of the results is also generated. The results of the on-line testing is viewable by the User on the Test Claim Referral Status Display screen

- There is a Report Generation selection that gives the User the ability to obtain paper printouts of current production claim referral criteria, test referral criteria, inactive referral criteria, and history referral criteria. The User can also use this selection to obtain statistical reporting.

CURRENTLY GENERATED FMR (SAS) REPORTS

1) *Claim Count of Bill Type*

2) *Revenue Code Ranking Report*

3) *HCPC Ranking Report by Revenue Code*

4) *Provider Ranking Report by HCPC Within Revenue Code*

5) *Provider Ranking Report within Revenue Code*

6) *Revenue Code Control Limit Report/Units (Occurrences) - Provider Aberrancy Data*

7) *Revenue Code Control Limit Report/Units (Occurrences) - Plotting Data*

8) *HCPCS Control Limit Report/Units (Occurrences) - Provider Aberrancy Data*

9) *HCPCS Control Limit Report/Units (Occurrences) - Plotting Data*

10) *HCFA Revenue Code Group Ranking Report*

11) *Provider Ranking Report within HCFA Revenue Code Group*

12) *Revenue Code Control Limit Report/Occurrences Per 100 Bene - Provider Aberrancy Data*

13) *Revenue Code Control Limit Report/Units (Occurrences) Per 100 Bene - Plotting Data*

14) *HCPCS Control Limit Report/Occurrences Per 100 Bene - Provider Aberrancy Data*

15) *HCPCS Control Limit Report/Units (Occurrences) Per 100 Bene - Plotting Data*

2. *FMR in Conjunction with Fraud and Abuse*

- Fraud and Abuse works with Medical Review staff on criteria for suspending claims for review.
- MCPS Medical Review provides capability for suspending all of a particular providers claims or certain claims for an individual provider based on aberrancies.

II. HOSPITAL BASED PHYSICIAN (HBP) DATA CROSSOVER

The hospital based physician (HBP) data crossover was implemented in the MCPS system in 1991, at the request of Aetna Phoenix and HCFA's San Francisco Regional Office. The original intent was to offer Part A providers a mechanism for submitting electronic media claims (EMC) to Aetna via direct data entry.

This function has the effect of increasing Aetna's EMC receipts. More over, customer service to providers is improved because submission of the professional component is more convenient.

- Allows the provider to submit the professional component along with the Medicare part A or Medicare part B of a claim.
- A one position indicator allows the provider access to the hospital based physician data screen (optional)
- The provider enters revenue code, HCPCS code, charge data, etc.
- Some editing is done during data entry.
- The professional component can be submitted with all bill types.
- The HBP data is stripped off prior to entry into the batch system by the system maintainer for crossover to Aetna.
- The providers using this function report significant time savings.

III. MULTI-ORGANIZATION PROCESSING

This function of MCPS allows several organizations (contractors/subcontractors) to process in one on-line/batch region with complete report and suspended claim routing capability. The routing for each organization is controlled from the Provider File. For identification purposes, each organization is designated a number 1-9. When a claim is entered and accepted by the system, the first position of the Documentation Control Number (DCN) equals the organization code on the Provider file.

This design feature was built into MCPS to facilitate shared processing from a common set of files. MTS is likely to require some feature that is conceptually similar, if not technically similar, in order to support the local contractor's access, reports for each local contractor and to create adequate record keeping capability for rolling-up individual transactions for CFO Act reporting.

1. Current Organizations on Multi-Organization Processing in MCPS

- Rural Health Clinics - (Code 2) because BCWP is the regional processor for RHC's, the adjudication of claims were pulled out separately for budgeting and reporting purposes (Recently RHC was combined into the overall HCFA Workload)
- Veritus Inc.
  - BCWP (Code 1) was consolidated with Capital Blue Cross (Code 5) and Blue Cross of Northeast (Code 4) in 1985 these plans retained the claim adjudication and Provider/Beneficiary servicing functions for their areas under a HCFA approved subcontracting agreement.
  - Plan code 1 has roll-up capabilities for consolidation of intermediary reporting
- Blue Cross and Blue Shield of Delaware (Plan code 6) was added to multi-plan processing in late 1989.

2. Batch Processing Job Stream/On-line Region

Multi-organization processing allows the Maintainer/Operator of the system to run all claims through one batch processing job stream. Multi-organization processing facilitates use of one on-line region for multiple plans.

- ♦ Cost effective (one region vs. several)
  - • less overhead required
- ♦ Safeguards accuracy and consistency of program changes/software applications
  - • single version of programs and one job stream instead of a copy of programs and a job stream for each region
  - • One set of edits vs. edits for each region

3. Report Routing/Claim Suspension by Organization Code

Information can be sorted by organization code for report generation to be used for budgeting, planning and for operational purposes.

- ♦ All reports and suspended claims are routed automatically to each particular organization by organization code.
  - Separate HCFA Workload reports by organization
  - Management reports
  - Adjudication of claim processing reports
- ♦ Security measures are in place to limit view access and adjudication of the claims by organization code
  - Authorization for access to organization specific suspended claims is controlled by Operator Identification

4. BENEFITS OF MULTI-ORGANIZATION PROCESSING CAPABILITY

- Enables operations to distribute work and reporting to multiple locations
- Facilitates efficient use of computer resources while processing multiple contractors/subcontractors
- Reduces effort and time required to apply system maintenance due to single source of programs and files.
- Minimal cost to build multi-processing capability into system at onset versus retrofitting to an existing system.

IV. SAME DAY CLAIMS CORRECTION

Same Day Correction, a feature unique to MCPS, allows the processor or provider to make corrections to a claim that was entered on the same day. This is a feature favored by the provider community.

- MCPS system automatically assigns a DCN the same day of entry. (Once the claim passes all the on-line edits
- Claims can be accessed the same day by DCN for error correction, additions or deletions.
- After same day correction, the claim goes back through the on-line edits and is assigned the same DCN.
- Providers find this a useful feature in case of an entry error or late date from various departments within the provider.

V. BULLETIN BOARD

The Electronic Bulletin Board is a means to communicate important information as quickly as possible to providers and appropriate internal staff within each plan.

- ♦ Can alert providers of Provider Bulletin notices mailed, upcoming changes, investigation status of problems or new procedures.

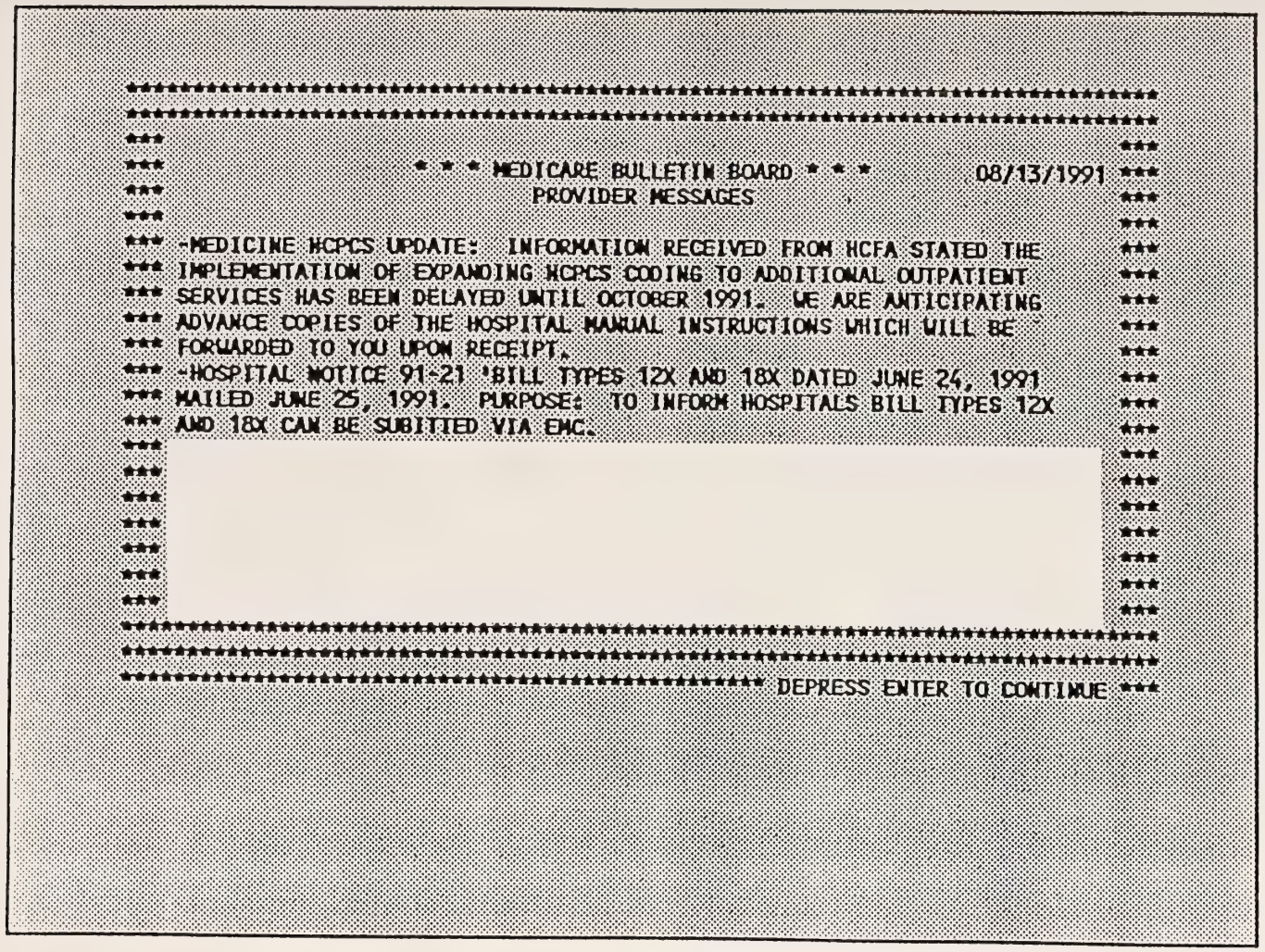
- ♦ The Bulletin Board is the first screen viewed after a provider or processor signs onto the system. This is not optional is MCPS. Creating the bulletin as the first screen without a select option assures that providers see important messages as a condition of entering the system, rather than have the option of "not opening the mail".

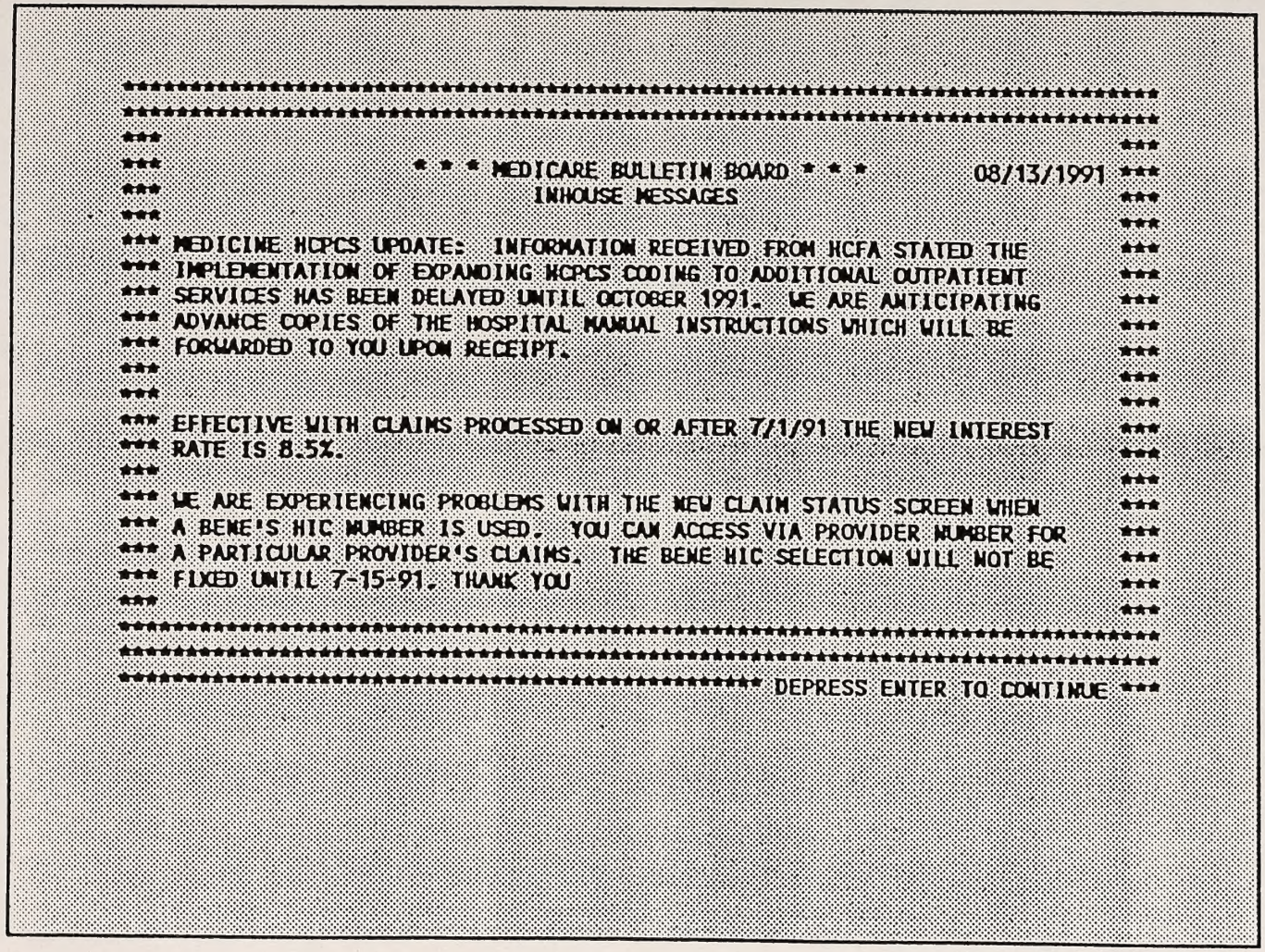
    - Two types of Bulletin Boards:

      Provider electronic bulletin board which the providers can view.

      Internal electronic bulletin board - which the internal staff can view. The internal staff can view both the provider and internal bulletin boards.

- ♦ Messages can be updated at anytime (real time).


* * * MEDICARE BULLETIN BOARD * * *
08/13/1991
PROVIDER MESSAGES
-MEDICINE HCPCS UPDATE: INFORMATION RECEIVED FROM HCFA STATED THE
IMPLEMENTATION OF EXPANDING HCPCS CODING TO ADDITIONAL OUTPATIENT
SERVICES HAS BEEN DELAYED UNTIL OCTOBER 1991. WE ARE ANTICIPATING
ADVANCE COPIES OF THE HOSPITAL MANUAL INSTRUCTIONS WHICH WILL BE
FORWARDED TO YOU UPON RECEIPT.
-HOSPITAL NOTICE 91-21 'BILL TYPES 12X AND 18X DATED JUNE 24, 1991
MAILED JUNE 25, 1991. PURPOSE: TO INFORM HOSPITALS BILL TYPES 12X
AND 18X CAN BE SUBITTED VIA EMC.
DEPRESS ENTER TO CONTINUE


* * * MEDICARE BULLETIN BOARD * * * 08/13/1991
INHOUSE MESSAGES
*** MEDICINE HCPCS UPDATE: INFORMATION RECEIVED FROM HCFA STATED THE
*** IMPLEMENTATION OF EXPANDING HCPCS CODING TO ADDITIONAL OUTPATIENT
*** SERVICES HAS BEEN DELAYED UNTIL OCTOBER 1991. WE ARE ANTICIPATING
*** ADVANCE COPIES OF THE HOSPITAL MANUAL INSTRUCTIONS WHICH WILL BE
*** FORWARDED TO YOU UPON RECEIPT.
*** EFFECTIVE WITH CLAIMS PROCESSED ON OR AFTER 7/1/91 THE NEW INTEREST
*** RATE IS 8.5%.
*** WE ARE EXPERIENCING PROBLEMS WITH THE NEW CLAIM STATUS SCREEN WHEN
*** A BENE'S HIC NUMBER IS USED. YOU CAN ACCESS VIA PROVIDER NUMBER FOR
*** A PARTICULAR PROVIDER'S CLAIMS. THE BENE HIC SELECTION WILL NOT BE
*** FIXED UNTIL 7-15-91. THANK YOU
*** DEPRESS ENTER TO CONTINUE ***

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